

FILED MAY 23 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 15168

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>441</u>	
1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Lawrence</u>			
b. CITY OR TOWN <u>Springfield</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>Ash Grove</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF (If in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Springfield Baptist Hospital</u>				f. STREET ADDRESS (If rural, give location) <u>R # 3. 1550</u>			
3. NAME OF DECEASED (Type or Print) <u>Cora</u>		a. (First) <u>Florence</u>		b. (Middle) _____		c. (Last) <u>Hendricks.</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>May 18 1955</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>Jan. 26, 1883</u>		9. AGE (In years last birthday) <u>72</u>		10. IF UNDER 1 YEAR: Months _____ Days _____		11. IF UNDER 4 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Oklahoma Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Newt Good</u>		13b. MOTHER'S MAIDEN NAME <u>Rosa Wheat.</u>		14. NAME OF HUSBAND OR WIFE <u>Roy L. Hendricks.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Cecil Hendricks, Son, Mt. Vernon, Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis -</u>  ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Fracture L. Hip</u> Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 day</u>  <u>2 mo</u> <u>2 yrs</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>5/13</u> 1955, to <u>5/18</u> 1955, that I last saw the deceased alive on <u>5/17</u> 1955, and that death occurred at <u>6:45</u> A. M., from the causes and on the date stated above.							
23a. SIGNATURE <u>J. P. Madary</u>		(Degree or title) <u>M.D.</u>		23b. ADDRESS <u>Springfield, Mo</u>		23c. DATE SIGNED <u>5/18/55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removed</u>		24b. DATE <u>5-18-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Kerr Chapel Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Billings, Christian Co Mo</u>	
DATE REC'D BY LOCAL REG. <u>5-19-55</u>		REGISTRAR'S SIGNATURE <u>Edith Williamson</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>N. O. Fossett Mt Vernon Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JUN 14 1955

### STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me; or by me....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed H. D. Lonssett.....

Licensed Embalmer No. 226

P. O. Address Mt. Vernon

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.